

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 6 See Birth Cert. et

13726

332

13716

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 46X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>103 West Eight Street</u>	
3. NAME OF DECEASED (Type or print) <u>Richard Spencer Barr</u>		4. DATE OF DEATH <u>December 14 - 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/57</u>
9. AGE (In years last birthday) <u>56</u> YR		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William S. Barr</u>		14. MOTHER'S MAIDEN NAME <u>VERA CHARKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William S. Barr</u>		Address <u>Laurel Del</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.1</u> <u>Congenital Cyanotic Heart Disease</u> DUE TO <u>Patent Ductus Arterialis</u> Blindly Ending Aorta Inter-ventricular Septal defect; Patent foramen ovale Functionally a Tricuspid Ateriosus (b) <u>5 DAYS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/9</u> , 19 <u>57</u> , to <u>12/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>57</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center Salisbury, Md</u>	
DATE SIGNED <u>12/14/57</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OLD Christ Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Dickerson</u>		ADDRESS <u>Laurel Del.</u>	
24a. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>18 1957</u>			

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DEC 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13717

CERTIFICATE OF DEATH

Reg. Dist. No.

1372837

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b x2 Hebron			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 1 Railroad Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle MC CREADY Last BENNETT				4. DATE OF DEATH Month DECEMBER Day 4 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1886		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 10 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee Wayne Pump Co. (Retired)		10b. KIND OF BUSINESS OR INDUSTRY (Retired)		11. BIRTHPLACE (State or foreign country) Mardela, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Ebenezer T. Bennett				14. MOTHER'S MAIDEN NAME Esther Virginia Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-6300		17. INFORMANT Address Mrs. Olive R. Bennett (Wife) Railroad Ave. Salisbury Hebron, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pancreatitis 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 22 days						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 4-10 , 19 55 , to 12-4 , 19 57 , that I last saw the deceased alive on 12-4 , 19 57 , and that death occurred at 3:10 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Earl L. Royer M.D. _____ PHYSICIAN'S NAME (Type) Dr. Earl L. Royer Camden Ave. Salisbury, Maryland Dec. 5 / 57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 6. 1957	22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery		22d. LOCATION (City, town, or county) (State) Mardela, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE DEC 9 1957		24b. REGISTRAR'S SIGNATURE Mary Holloway	

BUREAU V. E.

DEC 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1372837

Reg. Dist. No.

13718

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City 2342.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In route to Peninsula General Hosp.				d. STREET ADDRESS 2nd and Ceder Streets			
3. NAME OF DECEASED (Type or print) First ALMA Middle H. Last BLAINE				4. DATE OF DEATH Month December Day 21 , Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 70	IF UNDER 24 HRS. Days 70 Hours 70 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James P. Blaine				14. MOTHER'S MAIDEN NAME Mollie A. Hargis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-38-9180		17. INFORMANT Address Mrs Ida Scott, Pocomoke City, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) ACUTE MYOCARDIAL INFARCTION (c) HYPERTENSIVE CARDIO VASCULAR DISEASE						INTERVAL BETWEEN ONSET AND DEATH 3 HOURS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 12-21 , 19 57 , to 12-21 , 19 57 , that I last saw the deceased alive on 12-21 , 19 57 , and that death occurred at 2 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Stanford Hamilton M.D.				ADDRESS (Street, city or town, state) POCOMOKE CITY, MD.			
DATE SIGNED 12/21/57							
PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12-23-57	22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Dennis Watson				ADDRESS Pocomoke, Md.		24a. REC'D BY REGISTRAR DEC 20 1957	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 13762
 CERTIFICATE OF DEATH

Reg. Dist. No.

13789 ✓

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron - Rural				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Quantico Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ollie Middle Ellen Last Burris				4. DATE OF DEATH Month December Day 13 Year 1957			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1907	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Somerset Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edgar Jones				14. MOTHER'S MAIDEN NAME Julia White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-05-3746		17. INFORMANT Lonnie F. Burris, Hebron, Md., R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial Thrombosis DUE TO Cardio-Vascular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO Hypertension (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour 9 p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 1 , 19 55 , to Dec 13 , 19 57 , that I last saw the deceased alive on Dec 9 , 19 57 , and that death occurred at 2:30A M, from the causes and on the date stated above. ACTUAL SIGNATURE G Herbert Semblly M.D. Salisbury Md DATE SIGNED 12/14/57 PHYSICIAN'S NAME (Type) G Herbert Semblly							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Church Cemetery		22d. LOCATION (City, town, or county) (State) Quantico, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DEC 18 1957		24b. REGISTRAR'S SIGNATURE May H. Holloway	

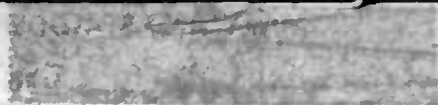
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WICOMICO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 YEAR				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ARCHIE CORNISH				4. DATE OF DEATH Month Day Year 12 2 1957			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ??		9. AGE (In years last birthday) 64 YEARS	IF UNDER 1 YEAR: Months Days Hours Min. 19 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLIND		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME DANIEL CORNISH				14. MOTHER'S MAIDEN NAME ELIZA BYRD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT DORTHY CORNISH PRINCESS ANNE MD. RED			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Cerebrovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 months Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 20 Oct , 19 57 , to 2 Dec , 19 57 , that I last saw the deceased alive on 2 Dec 1957 , and that death occurred at 10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6520 main ST Salisbury, Md DATE SIGNED 6 Dec 57 ACTUAL SIGNATURE E. A. Purcell M.D. Salisbury, Md PHYSICIAN'S NAME (Type) E. A. Purcell, M.D. Salisbury, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/57		22c. NAME OF CEMETERY OR CREMATORY Wagon		22d. LOCATION (City, town, or county) (State) Back Road Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Princess Anne, Md				24a. REC'D BY REGISTRAR DATE 12-7-57		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

STATEMENT OF DEATH



NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
MARRIED		SINGLE		EDUCATION	
RELIGION		RACE		ETHNIC ORIGIN	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	

RECEIVED
DEC 10 1957
BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13720 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13731
822

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. STREET ADDRESS 116 Fooks St.	
3. NAME OF DECEASED (Type or print) John Simpson Coulter 3rd		4. DATE OF DEATH 12-8-1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1957
9. AGE (In years last birthday) 0 yrs.		10. IF FUNDER 1 YEAR 32 Months 6 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland-Salisbury Hosp.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Simpson Coulter Jr		14. MOTHER'S MAIDEN NAME Irene Beatrice Wilkerson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. John S. Coulter (Father)		Address 116 Fook St. Salisbury, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 500x IMMEDIATE CAUSE (a) Acute laryngo-tracheo-bronchitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , <u>Accident</u> <input type="checkbox"/> , <u>Suicide</u> <input type="checkbox"/> , <u>Homicide</u> <input type="checkbox"/> , <u>Undetermined monner</u> <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 12-10-57	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1957	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DEC 11 1957	
		24b. REGISTRAR'S SIGNATURE Mary T. Holloway	

2082252XV4

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

DECEASED
1957

Place of Death

John A. ...

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RECEIVED
DEC 11 1957
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(13732)

13721

CERTIFICATE OF DEATH

Reg. Dist. No. 13732

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 WK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BRIAN</u> First <u>DOUGLAS</u> Middle <u>C</u> Last <u>CULVER</u>				4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/2/1955</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BABY</u>		9. AGE (In years last birthday) <u>2</u> yrs. Months <u>11</u> Days <u>12</u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>ROBERT L. CULVER, SR.</u>			
14. MOTHER'S MAIDEN NAME <u>Ruth CHAFFEY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u></u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>ROBERT L. CULVER, Sr.</u> Address <u>SAME.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hepatic Failure</u> <u>092X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatitis, acute - ? Serum infection</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 weeks</u>	
PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Leukemia, acute lymphocytic</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 7</u> 19 <u>57</u> , to <u>Dec 14</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 14</u> 19 <u>57</u> , and that death occurred at <u>3</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. Saunderson Jr.</u> M.D. <u>976 Division St.</u>				DATE SIGNED <u>12/14/57</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT W. SAUNDERSON JR. Salisbury Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12/17/1957</u>		<u>PARSONS CEMETERY</u>		<u>SALISBURY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Will Johnson</u> ADDRESS <u>Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 12-10-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name: <u>Robert L. Colburn</u>		Sex: <u>Male</u>	
Date of Birth: <u>11/11/22</u>		Place of Birth: <u>St. Louis, Mo.</u>	
Occupation: <u>None</u>		Cause of Death: <u>Brain</u>	
Date of Death: <u>11/11/22</u>		Time of Death: <u>10:00</u>	
Place of Death: <u>St. Louis, Mo.</u>		Physician: <u>Douglas</u>	
Signature: <u>Robert L. Colburn</u>		Signature: <u>Douglas</u>	
Witness: <u>None</u>		Witness: <u>None</u>	
Burial: <u>None</u>		Burial: <u>None</u>	
Cremation: <u>None</u>		Cremation: <u>None</u>	
Other: <u>None</u>		Other: <u>None</u>	

BUREAU V. E.

DEC 19 1957

RECEIVED

Robert L. Colburn

Robert L. Colburn

Robert L. Colburn

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13733

13763

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		c. LENGTH OF STAY IN 1b 3 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mamie Xx Curtis		4. DATE OF DEATH 12-12-1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1888
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Jeannie Newcomb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Husband: Elmer Curtis Hebron, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.0 DUE TO Acute Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerotic Heart Disease (b) Arteriosclerotic Heart Disease (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH hours you	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-12-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 12-13-57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson		24a. REC'D BY REGISTRAR 12-17-1957	
ADDRESS Princess Anne, Md.		24b. REGISTRAR'S SIGNATURE Mary M. Hall	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 17 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13722

CERTIFICATE OF DEATH

13734

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> <i>md</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> c. LENGTH OF STAY IN 1b <i>Life</i>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Wicomico</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury md 12</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>512 Tanger St.</i>	
3. NAME OF DECEASED (Type or print) <i>Atwood S Doshill</i> First Middle Last		4. DATE OF DEATH <i>12-1-1957</i> Month Day Year	
5. SEX <i>m</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1894</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	9. AGE (In years last birthday) <i>63</i> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Domes Quarter md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Centrow</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>Lillie Doshill</i> Address <i>512 Tanger St</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Stomach</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-22</i> , 1957, to <i>12-1</i> , 1957, that I last saw the deceased alive on <i>11-30</i> , 1957, and that death occurred at <i>M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Earl L Royer</i> M.D.		ADDRESS (Street, city or town, state) <i>407 Camden St Salisbury md</i> DATE SIGNED <i>12-4-57</i>	
PHYSICIAN'S NAME (Type) <i>Earl L Royer</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-6-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brown Heres Am</i>	22d. LOCATION (City, town, or county) (State) <i>Salisbury md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. J. M. Leesh</i> ADDRESS		24a. REC'D BY REGISTRAR <i>DEC 9 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Mary Halloway</i>

BUREAU V. S.

DEC 9 1957

RECEIVED

13764

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela				c. LENGTH OF STAY IN 1b 25 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Georgia Middle Anna Last Dashiell				4. DATE OF DEATH Month December Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 28, 1893	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Accomack, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Wise				14. MOTHER'S MAIDEN NAME Esther (maiden name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-4148		17. INFORMANT Ira A. Dashiell, Mardela, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 452x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) antemortem aneurysm external carotid right DUE TO (c) unknown							INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute pyelonephritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 57 , to death , 19 57 , that I last saw the deceased alive on Dec 15 , 19 57 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 100 Grove Delmar, Del DATE SIGNED 12/17/57 ACTUAL SIGNATURE Ernest M. Larmore M.D. 100 GROVE DELMAR, DEL PHYSICIAN'S NAME (Type) ERNEST LARMORE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 22, 1957		22c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery		22d. LOCATION (City, town, or county) (State) Mardela, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DEC 23 1957		24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 23 1957

RECEIVED

CERTIFICATE OF DEATH

13736

332

Reg. Dist. No.

13765

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Fruitland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Isabella Street</u>				d. STREET ADDRESS <u>Isabella Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Hannah</u> First Middle Last				4. DATE OF DEATH <u>12</u> Month <u>10</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Virgil Deal Fruitland Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebroscloposis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Indefinite</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10 Sept</u> 19 <u>57</u> to <u>10 Dec</u> 19 <u>57</u> , that I last saw the deceased alive on <u>10 Dec</u> 19 <u>57</u> , and that death occurred at <u>7:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. A. Purnell</u>				ADDRESS (Street, city or town, state) <u>652 W main St., Salisbury, Maryland</u>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 13 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Fruitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>				24. REC'D BY REGISTRAR <u>DEC 16 1957</u> DATE			
25. REGISTRAR'S SIGNATURE <u>Mary M. Holloway</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

DEC 16 1957

RECEIVED

13723

CERTIFICATE OF DEATH

Reg. Dist. No.

13737

332

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 44 Cherry Way	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First COLLEY Middle DILL Last DILL		4. DATE OF DEATH Month DECEMBER Day 26th Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1902
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 3 Days 9	
IF UNDER 24 HRS. Hours 3 Min. 9			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Employee		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Alexander Dill		14. MOTHER'S MAIDEN NAME Priscilla -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		17. INFORMANT Mrs. Norma G. Scott (Daughter) Address #44 Cherry Way Salisbury, Maryland	
16. SOCIAL SECURITY NO.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/7 , 19 57 , to 12/26 , 19 57 , that I last saw the deceased alive on 12/26 , 19 57 , and that death occurred at 7:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE AC Mitchell M.D.			
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell		Maryland Ave. Salisbury, Md. Dec. 127 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 29, 1957	22c. NAME OF CEMETERY OR CREMATORY Odd Fellow Cemetery	22d. LOCATION (City, town, or county) (State) Camden, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE TORBERT FUNERAL SERVICE - DOVER, DELAWARE		24a. REC'D BY REGISTRAR DEC 30 1957	
24b. REGISTRAR'S SIGNATURE Mary Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John A. Smith		Male		35		Jan. 15, 1905		Baltimore, Md.	
Cause of Death		Disease		Occupation		Residence		Burial Place	
Heart Disease		Myocarditis		Carpenter		1234 N. Main St.		St. John's Church	
Physician's Certificate		Medical Examiner's Certificate		Coroner's Certificate		Burial Certificate		Death Certificate	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
BUREAU V. R.
JAN 30 1907

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13724

CERTIFICATE OF DEATH

Reg. Dist. No. 13738 32

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 Martin St				d. STREET ADDRESS 306 Martin St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) IDA		First IDA		Middle ISABELLE		Last DILL	
4. DATE OF DEATH Month DECEMBER Day 30th Year 19 57							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1877		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 11 Days 16	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bishopville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Campbell				14. MOTHER'S MAIDEN NAME Sallie Hudson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Ida Mae Swinehart (Daughter) Address 306 Martin St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) degenerative heart disease DUE TO Syr. (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. 19 Manth, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/15 , 19 57 , to 12/30 , 19 57 , that I last saw the deceased alive on 12/30 , 19 57 , and that death occurred at 10:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Paul A. Beardsley M.D. Dec 30/57							
ACTUAL SIGNATURE Paul A. Beardsley							
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley Maryland Ave. Salisbury, Maryland Dec 30/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JAN 3 1958		24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 3 1939

BUREAU V. 1

RECEIVED		JAN 3 1939		BUREAU V. 1	
1. NAME OF DECEASED		2. DATE OF DEATH		3. PLACE OF DEATH	
4. SEX		5. AGE		6. OCCUPATION	
7. MARITAL STATUS		8. EDUCATION		9. RELIGION	
10. BIRTH DATE		11. BIRTH PLACE		12. CITIZENSHIP	
13. MOTHER'S NAME		14. FATHER'S NAME		15. MARRIAGE DATE	
16. MARRIAGE PLACE		17. MARRIAGE TYPE		18. MARRIAGE LICENSE	
19. MARRIAGE OFFICIAL		20. MARRIAGE WITNESSES		21. MARRIAGE VOUCHER	
22. MARRIAGE CERTIFICATE		23. MARRIAGE RECORD		24. MARRIAGE INDEX	
25. MARRIAGE SEARCH		26. MARRIAGE COPY		27. MARRIAGE FILE	
28. MARRIAGE ENTRY		29. MARRIAGE LIST		30. MARRIAGE SUMMARY	
31. MARRIAGE TOTAL		32. MARRIAGE AVERAGE		33. MARRIAGE STANDARD	
34. MARRIAGE DEVIATION		35. MARRIAGE CORRELATION		36. MARRIAGE REGRESSION	
37. MARRIAGE COEFFICIENT		38. MARRIAGE CONSTANT		39. MARRIAGE VARIABLE	
40. MARRIAGE PARAMETER		41. MARRIAGE STATISTIC		42. MARRIAGE ANALYSIS	
43. MARRIAGE INTERPRETATION		44. MARRIAGE CONCLUSION		45. MARRIAGE RECOMMENDATION	
46. MARRIAGE ACTION		47. MARRIAGE FOLLOW-UP		48. MARRIAGE EVALUATION	
49. MARRIAGE IMPROVEMENT		50. MARRIAGE MAINTENANCE		51. MARRIAGE PROTECTION	
52. MARRIAGE PRESERVATION		53. MARRIAGE RESTORATION		54. MARRIAGE REPAIR	
55. MARRIAGE RECONSTRUCTION		56. MARRIAGE REFORMATION		57. MARRIAGE REGENERATION	
58. MARRIAGE REINFORCEMENT		59. MARRIAGE REINFORCEMENT		60. MARRIAGE REINFORCEMENT	
61. MARRIAGE REINFORCEMENT		62. MARRIAGE REINFORCEMENT		63. MARRIAGE REINFORCEMENT	
64. MARRIAGE REINFORCEMENT		65. MARRIAGE REINFORCEMENT		66. MARRIAGE REINFORCEMENT	
67. MARRIAGE REINFORCEMENT		68. MARRIAGE REINFORCEMENT		69. MARRIAGE REINFORCEMENT	
70. MARRIAGE REINFORCEMENT		71. MARRIAGE REINFORCEMENT		72. MARRIAGE REINFORCEMENT	
73. MARRIAGE REINFORCEMENT		74. MARRIAGE REINFORCEMENT		75. MARRIAGE REINFORCEMENT	
76. MARRIAGE REINFORCEMENT		77. MARRIAGE REINFORCEMENT		78. MARRIAGE REINFORCEMENT	
79. MARRIAGE REINFORCEMENT		80. MARRIAGE REINFORCEMENT		81. MARRIAGE REINFORCEMENT	
82. MARRIAGE REINFORCEMENT		83. MARRIAGE REINFORCEMENT		84. MARRIAGE REINFORCEMENT	
85. MARRIAGE REINFORCEMENT		86. MARRIAGE REINFORCEMENT		87. MARRIAGE REINFORCEMENT	
88. MARRIAGE REINFORCEMENT		89. MARRIAGE REINFORCEMENT		90. MARRIAGE REINFORCEMENT	
91. MARRIAGE REINFORCEMENT		92. MARRIAGE REINFORCEMENT		93. MARRIAGE REINFORCEMENT	
94. MARRIAGE REINFORCEMENT		95. MARRIAGE REINFORCEMENT		96. MARRIAGE REINFORCEMENT	
97. MARRIAGE REINFORCEMENT		98. MARRIAGE REINFORCEMENT		99. MARRIAGE REINFORCEMENT	
100. MARRIAGE REINFORCEMENT		101. MARRIAGE REINFORCEMENT		102. MARRIAGE REINFORCEMENT	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1

13725

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13734
337

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Pocomoke City 19x2.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRINGHILL SANITARIUM</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SALLIE C. DRYDEN</u>				4. DATE OF DEATH Month Day Year <u>DEC. 26 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 14-1872</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH W. TILGHMAN</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE CLUFF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT Address <u>CLIFFORD M. DRYDEN, Pocomoke</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1957</u> , to <u>Dec. 26, 1957</u> , that I last saw the deceased alive on <u>Dec. 20, 1957</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>Dec. 27, 1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN</u>		22d. LOCATION (City, town, or county) (State) <u>REHOBOTH MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u> ADDRESS <u>Pocomoke Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 30 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The both copies may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13766 CERTIFICATE OF DEATH

13740

335

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>		LENGTH OF STAY (in this place) <u>20 yrs</u>		STREET ADDRESS (If rural give location) <u>Railway Street</u>		STREET ADDRESS (If rural give location) <u>Railway Street</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Railway Street</u>				STREET ADDRESS (If rural give location) <u>Railway Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Pearl</u> <u>Eaton</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 23</u> <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 9, 1878</u>		9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Benjamin Eaton, Sharptown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension + Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Vascular Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/25</u>, 19<u>55</u>, to <u>12/23</u>, 19<u>57</u>, that I last saw the deceased alive on <u>12/23</u>, 19<u>57</u>, and that death occurred at <u>6 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Charles M. May</u>				ADDRESS (Street, city, town, state) <u>Sharptown, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>12-26-57</u>		NAME OF CEMETERY OR CREMATORY <u>Firemans</u>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE <u>Mary C. Owens</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Gandy, Sharptown, Md.</u>	
DATE <u>DEC 30 1957</u>							

CERTIFICATE OF DEATH

NO. 1000

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. DATE OF DEATH

12. TIME OF DEATH

13. PLACE OF INTERMENT

14. SIGNATURE OF REGISTRAR

15. NAME OF WITNESS

16. ADDRESS OF WITNESS

17. SIGNATURE OF WITNESS

18. DATE OF SIGNATURE

19. NAME OF DECEASED

20. SEX

21. AGE

22. OCCUPATION

23. PLACE OF BIRTH

24. DATE OF BIRTH

25. PLACE OF DEATH

26. SIGNATURE OF PHYSICIAN

27. DATE OF DEATH

28. TIME OF DEATH

29. PLACE OF INTERMENT

30. SIGNATURE OF REGISTRAR

31. NAME OF WITNESS

32. ADDRESS OF WITNESS

33. SIGNATURE OF WITNESS

34. DATE OF SIGNATURE

35. NAME OF DECEASED

36. SEX

37. AGE

38. OCCUPATION

39. PLACE OF BIRTH

40. DATE OF BIRTH

41. PLACE OF DEATH

42. SIGNATURE OF PHYSICIAN

43. DATE OF DEATH

44. TIME OF DEATH

45. PLACE OF INTERMENT

46. SIGNATURE OF REGISTRAR

47. NAME OF WITNESS

48. ADDRESS OF WITNESS

49. SIGNATURE OF WITNESS

50. DATE OF SIGNATURE

51. NAME OF DECEASED

52. SEX

53. AGE

54. OCCUPATION

55. PLACE OF BIRTH

56. DATE OF BIRTH

57. PLACE OF DEATH

58. SIGNATURE OF PHYSICIAN

59. DATE OF DEATH

60. TIME OF DEATH

61. PLACE OF INTERMENT

62. SIGNATURE OF REGISTRAR

63. NAME OF WITNESS

64. ADDRESS OF WITNESS

65. SIGNATURE OF WITNESS

66. DATE OF SIGNATURE

67. NAME OF DECEASED

68. SEX

69. AGE

70. OCCUPATION

71. PLACE OF BIRTH

72. DATE OF BIRTH

73. PLACE OF DEATH

74. SIGNATURE OF PHYSICIAN

BUREAU V. 21

DEC 30 1957

RECEIVED

Charles W. McNamee, Registrar

CERTIFICATE OF DEATH

13741

13726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> 19X12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>				d. STREET ADDRESS <u>Princess Anne Md.</u>			
3. NAME OF DECEASED (Type or print) <u>Dalentine E. Eby</u>				4. DATE OF DEATH <u>December 31 - 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14 1886</u> 11 yrs.	
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Samuel E. Eby</u>			
14. MOTHER'S MAIDEN NAME <u>Harriett Chafer</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>World War I</u> 217-30-8043			
16. SOCIAL SECURITY NO. <u>217-30-8043</u>				17. INFORMANT <u>Mrs Robert Street Princess Anne</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized abdominal carcinomatosis</u> 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Ampulla of Vater</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12-25-1957</u> , to <u>12-31-1957</u> , that I last saw the deceased alive on <u>12-31-57</u> , 19____, and that death occurred at <u>11:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Fisher Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
DATE SIGNED				DATE SIGNED			
PHYSICIAN'S NAME (Type)				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 3 1958</u>		<u>Episcopal Cemetery Princess Anne Md.</u>		<u>Princess Anne Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Shannon Princess Anne Md.</u>				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>Mary H. Clary</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

JAN 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13767 CERTIFICATE OF DEATH

13742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 (Zion Rd)		d. STREET ADDRESS R.D.# 3 (Zion Rd)	
3. NAME OF DECEASED (Type or print) First EDITH Middle MATILDA Last FARLOW		4. DATE OF DEATH Month DECEMBER Day 21st Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 16 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Wicomico County Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Handy Livingston		14. MOTHER'S MAIDEN NAME Gertrude Matilda Russk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. George W. Farlow (Husband)		Address R.D.# 3 Zion Rd. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1946 , to 12-21-57 , 19 57 , that I last saw the deceased alive on 12-21-57 , 19 57 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lee Lawry		M.D. Fruitland, Md.	
PHYSICIAN'S NAME (Type) Dr. Lee Lawry		Fruitland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23, 1957	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24. REC'D BY REGISTRAR DEC 27 1957 REGISTRAR'S SIGNATURE Mary Holloway	

• *United States*

Journal of Management Education 33(1)

Mr. George W. Fisher (Chairman)

Constance M. East

15-2-15-9-14

BUREAU V.

DEC 27 1957

RECEIVED

13727

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 2yrs3mo.16days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland 0913.2			
4. DATE OF DEATH Month Dec. Day 15 Year 57				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ethel Middle Ball Last Fountain				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Oct. 2, 1877				9. AGE (In years last birthday) yrs. 80			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk				10b. KIND OF BUSINESS OR INDUSTRY unk			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Anderton Fountain				14. MOTHER'S MAIDEN NAME Wilhelmina Mills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk				16. SOCIAL SECURITY NO. unk			
17. INFORMANT Hospital Records				Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertensive arterioslerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH yrs. DUE TO Acute heart failure 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug. 8, 19 55, to Dec. 15, 19 57, that I last saw the deceased alive on Dec. 15, 19 57, and that death occurred at 9:09 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Salisbury, Maryland				DATE SIGNED 12/15/57			
ACTUAL SIGNATURE Gerhard Kosmahly M.D.				PHYSICIAN'S NAME (Type) Gerhard Kosmahly, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/57		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge Md	
23. FUNERAL DIRECTOR'S SIGNATURE John LeCroy				24a. REC'D BY REGISTRAR John LeCroy		24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		45		M		W		1880		NEW YORK		NEW YORK		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
100 N. BOSTON ST.		LABORER		HEART DISEASE		NATURAL		DEC 15 1957		BOSTON		MASSACHUSETTS		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
DEC 15 1957		BOSTON		MASSACHUSETTS		UNITED STATES		DEC 15 1957		BOSTON		MASSACHUSETTS		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
DEC 15 1957		BOSTON		MASSACHUSETTS		UNITED STATES		DEC 15 1957		BOSTON		MASSACHUSETTS		UNITED STATES	

MASSACHUSETTS DEPARTMENT OF HEALTH

BUREAU V. S.

DEC 23 1957

RECEIVED

13728

CERTIFICATE OF DEATH

Reg. Dist. No.

33r

1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND				b. COUNTY WORCESTER.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 1 Day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY 23X2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELIJAH THOMAS GARLICK				4. DATE OF DEATH Month Day Year DECEMBER 2 1957							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 19, 1880		9. AGE (In years lost birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PUBLISHER				10b. KIND OF BUSINESS OR INDUSTRY DAILY PAPER				11. BIRTHPLACE (State or foreign country) OLDHAM, ENGLAND			
12. CITIZEN OF WHAT COUNTRY? USA.				13. FATHER'S NAME JAMES WILLIAM GARLICK				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No				17. INFORMANT MR. S. WILLIAM GARLICK, OCEAN CITY, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO (b) Myocardial infarction DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Berlin				20g. (County) MD				20h. (State)			
21. I certify that I attended the deceased from 12:12, 1957, to 12:12, 1957, that I last saw the deceased alive on 12:12, 1957, and that death occurred at 11:55 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE H. P. Briele				ADDRESS (Street, city or town, state) Medical Center				DATE SIGNED 12-3-57			
PHYSICIAN'S NAME (Type) H. P. Briele											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 12/6/57				22c. NAME OF CEMETERY OR CREMATORY EVERGREEN			
22d. LOCATION (City, town, or county) BERLIN				22e. (State) MD							
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burby				ADDRESS Berlin and				24a. REC'D BY REGISTRAR DEC 5 1957			
24b. REGISTRAR'S SIGNATURE Mary H. Holloway											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES W. GUNN		JAN. 12, 1957	
AGE		SEX	
77		M	
RACE		OCCUPATION	
W		RETIRED	
BIRTHPLACE		PLACE OF BIRTH	
U.S.A.		U.S.A.	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
IMMEDIATE CAUSE		FURTHER INFORMATION	
CORONARY THROMBOSIS		DECEASED WAS UNDER MEDICAL ATTENTION	
PREVIOUS ILLNESS		DATE OF ONSET	
HYPERTENSION		JAN. 1, 1957	
PREVIOUS SURGERY		DATE OF SURGERY	
NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. GUNN		J. H. GUNN	
DATE		DATE	
JAN. 12, 1957		JAN. 12, 1957	

BUREAU V. 3

JAN 15 1957

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 8 & 9, Film G225. 2/14/58 fcy

CERTIFICATE OF DEATH

13746

332

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		STATE <i>MD</i> COUNTY <i>Wicomico</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Dalshbury</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Dalshbury</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Dalshbury</i>		LENGTH OF STAY (in this place) <i>70</i>		STREET ADDRESS <i>1</i>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last) <i>Jannie L Gandy</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>12 29 1957</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>2-27-1900?</i>	9. AGE last birthday <i>58?</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>S.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Paul Hogood</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-4-3382</i>		17. INFORMANT & ADDRESS <i>Howard Gandy</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
591X IMMEDIATE CAUSE (A) <i>Uremia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>subacute glomerulonephritis</i>				<i>10 months</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Hypertension, hypertensive heart disease</i>				<i>2</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 29, 1957</i> , to <i>Dec 29, 1957</i> , that I last saw the deceased alive on <i>Dec 29, 1957</i> , and that death occurred at <i>10:20 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>A. V. S. Oiler</i> M.D.				ADDRESS (Street, city, town, state) <i>Delmar, Md.</i>		DATE SIGNED <i>12-30-57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-2-57</i>		NAME OF CEMETERY OR CREMATORY <i>Blue Hill Cem</i>		LOCATION (City, town, or county) (State) <i>Parsonsbury Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary Mollaway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Booker S. Black</i>		ADDRESS	
DATE <i>JAN 6 1958</i>							

CERTIFICATE OF DEATH

FILE NO.

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

8

2-27-00

2-27-00

F

John H. Hays

20-11-88

John H. Hays

BUREAU V. 1

JAN 6 1903

RECEIVED

John H. Hays

2-27-00

John H. Hays

ENCLOSURE

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13768 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13745
33

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Georgia Emily Gates</u>		4. DATE OF DEATH Month Day Year <u>12 19 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>68(11-12-1889) 68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>George Price</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-3636</u>	
17. INFORMANT <u>Mrs. Emma Dorman, Quantico, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic cardio-vascular disease</u> (c) <u>Years</u> DUE TO (a) <u>stoking the underlying cause fast.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>12-20-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 12-22-57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Head Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Quantico, R F D # 1, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home Salisbury, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 27 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary Hall</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEATH CERT.

MISSOURI STATE DEPARTMENT OF HEALTH - KANSAS CITY
1957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957-12-07

BUREAU V. 1

DEC 97 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13730 CERTIFICATE OF DEATH

13747
937

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place) 2 1/2 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural-Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Bluff State Hospital				STREET ADDRESS (If rural give location) R.F.D. # 2			
3. NAME OF DECEASED (Type or Print) Emma Elizabeth Haddock				4. DATE OF DEATH Dec. 8 19 57			
5. SEX F		6. COLOR OR RACE W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W		8. DATE OF BIRTH Feb. 28, 1884	
9. AGE last birthday 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Ellingsworth				14. MOTHER'S MAIDEN NAME Martha Tumie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mr. William A. Haddock (Son) Records of Pine Bluff State Hosp. R.D. #2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
002X IMMEDIATE CAUSE (A) Pulmonary tuberculosis				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jul. 1, 19 57, to Dec. 8, 19 57, that I last saw the deceased alive on Dec. 7, 19 57, and that death occurred at 7:30p M., from the causes and on the date stated above 12/8/57							
SIGNATURE E.P. Ritchings, M.D.				ADDRESS (Street, city, town, state) 1240 STONED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec 11, 1957		NAME OF CEMETERY OR CREMATORY Line Church Cemetery		LOCATION (City, town, or county) R.D. # Pittsville, Maryland	
24. REC'D BY REGISTRAR DATE DEC 11 1957		REGISTRAR'S SIGNATURE Mary J. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME -SALISBURY, MD.			

CERTIFICATE OF DEATH

Page One

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JURY

16. SIGNATURE OF COURT

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF TOWNSHIP CLERK

21. SIGNATURE OF COUNTY CLERK

22. SIGNATURE OF STATE CLERK

23. SIGNATURE OF FEDERAL CLERK

24. SIGNATURE OF MARSHAL

25. SIGNATURE OF DEPUTY MARSHAL

26. SIGNATURE OF SHERIFF'S DEPUTY

27. SIGNATURE OF TOWNSHIP SHERIFF

28. SIGNATURE OF COUNTY SHERIFF

29. SIGNATURE OF STATE SHERIFF

30. SIGNATURE OF FEDERAL SHERIFF

31. SIGNATURE OF MARSHAL'S DEPUTY

32. SIGNATURE OF DEPUTY MARSHAL'S DEPUTY

33. SIGNATURE OF SHERIFF'S DEPUTY'S DEPUTY

34. SIGNATURE OF TOWNSHIP SHERIFF'S DEPUTY

35. SIGNATURE OF COUNTY SHERIFF'S DEPUTY

36. SIGNATURE OF STATE SHERIFF'S DEPUTY

37. SIGNATURE OF FEDERAL SHERIFF'S DEPUTY

38. SIGNATURE OF MARSHAL'S DEPUTY'S DEPUTY

39. SIGNATURE OF DEPUTY MARSHAL'S DEPUTY'S DEPUTY

40. SIGNATURE OF SHERIFF'S DEPUTY'S DEPUTY'S DEPUTY

41. SIGNATURE OF TOWNSHIP SHERIFF'S DEPUTY'S DEPUTY

42. SIGNATURE OF COUNTY SHERIFF'S DEPUTY'S DEPUTY

43. SIGNATURE OF STATE SHERIFF'S DEPUTY'S DEPUTY

44. SIGNATURE OF FEDERAL SHERIFF'S DEPUTY'S DEPUTY

45. SIGNATURE OF MARSHAL'S DEPUTY'S DEPUTY'S DEPUTY

46. SIGNATURE OF DEPUTY MARSHAL'S DEPUTY'S DEPUTY'S DEPUTY

47. SIGNATURE OF SHERIFF'S DEPUTY'S DEPUTY'S DEPUTY'S DEPUTY

48. SIGNATURE OF TOWNSHIP SHERIFF'S DEPUTY'S DEPUTY'S DEPUTY

49. SIGNATURE OF COUNTY SHERIFF'S DEPUTY'S DEPUTY'S DEPUTY

50. SIGNATURE OF STATE SHERIFF'S DEPUTY'S DEPUTY'S DEPUTY

51. SIGNATURE OF FEDERAL SHERIFF'S DEPUTY'S DEPUTY'S DEPUTY

BUREAU V. S.

DEC 11 1957

RECEIVED

13731

CERTIFICATE OF DEATH

13748

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 2.4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Helen Middle Hayes Last Dec.				4. DATE OF DEATH Month Dec. Day 3 Year 19 57			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/17/1914	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 4 Days 3 Hours 19 Min.		IF UNDER 24 HRS. Months 4 Days 3 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Frank Abrams				14. MOTHER'S MAIDEN NAME Anna Francis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laennec's cirrhosis of liver DUE TO (c)							4 days 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 3 , 1957 , to Dec. 3 , 1957 , that I last saw the deceased alive on Dec. 3 , 1957 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. J. Juerman				ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/4/57			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-8-57		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese				ADDRESS 108 West St. Annapolis Md		24a. REC'D BY REGISTRAR 12/9/57 24b. REGISTRAR'S SIGNATURE Mary K. Holloway	

BUREAU V. S.

DEC 10 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13749

13732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 338

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Elizabeth Hitchens		4. DATE OF DEATH 12-20-1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 2, 1892
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Wilson		14. MOTHER'S MAIDEN NAME Sarah Hitchens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) X		16. SOCIAL SECURITY NO. 214-30-8695	
17. INFORMANT Arthur Hitchens, Delmar, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2nd and 3rd degree burns of 80% of body surface. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden. 9 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Clothing caught fire when stove exploded.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12-11-1957 p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing home.	20f. (City or town) Delmar (County) (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 12-23-57	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-22-57	22c. NAME OF CEMETERY OR CREMATORY First Methodist	22d. LOCATION (City, town, or county) (State) Delmar, Del.
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Marshall Co - Delmar, Kent		24a. REC'D BY REGISTRAR DEC 27 1957	24b. REGISTRAR'S SIGNATURE Mary H. Hollaway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE IS
1957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination details, including fields for name, date, time, and location. The text is mirrored and difficult to read.

BUREAU V. B.

DEC 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13769

CERTIFICATE OF DEATH

13750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar Md. x 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Holloway Nursing Home</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Levin</u> Middle <u>Franklin</u> Last <u>Holbrook</u>		4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>not known</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min. <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Former Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Stanley Holbrook</u>		14. MOTHER'S MAIDEN NAME <u>Ella Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Gladys Brown Sharptown Md.</u>	
17. INFORMANT <u>Gladys Brown Sharptown Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO <u>Unknown</u> (c) <u>Hypertension</u> DUE TO <u>Unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unknown</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 22</u> , 19 <u>57</u> , to <u>Dec 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>57</u> , and that death occurred at <u>6</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Dembly</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u>	
DATE SIGNED <u>12/6/57</u>			
PHYSICIAN'S NAME (Type) <u>G. Herbert Dembly</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 9/ 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		ADDRESS <u>Salisbury Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 9 57</u>		24b. REGISTRAR'S SIGNATURE <u>One</u>	

CERTIFICATE OF DEATH

Form 10-1-18

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	
13. Name of informant		14. Address of informant		15. Telephone number	
16. Name of funeral home		17. Address of funeral home		18. Telephone number	
19. Name of cemetery		20. Address of cemetery		21. Telephone number	
22. Name of undertaker		23. Address of undertaker		24. Telephone number	
25. Name of physician		26. Address of physician		27. Telephone number	
28. Name of registrar		29. Address of registrar		30. Telephone number	
31. Name of informant		32. Address of informant		33. Telephone number	
34. Name of funeral home		35. Address of funeral home		36. Telephone number	
37. Name of cemetery		38. Address of cemetery		39. Telephone number	
40. Name of undertaker		41. Address of undertaker		42. Telephone number	
43. Name of physician		44. Address of physician		45. Telephone number	
46. Name of registrar		47. Address of registrar		48. Telephone number	
49. Name of informant		50. Address of informant		51. Telephone number	
52. Name of funeral home		53. Address of funeral home		54. Telephone number	
55. Name of cemetery		56. Address of cemetery		57. Telephone number	
58. Name of undertaker		59. Address of undertaker		60. Telephone number	
61. Name of physician		62. Address of physician		63. Telephone number	
64. Name of registrar		65. Address of registrar		66. Telephone number	
67. Name of informant		68. Address of informant		69. Telephone number	
70. Name of funeral home		71. Address of funeral home		72. Telephone number	
73. Name of cemetery		74. Address of cemetery		75. Telephone number	
76. Name of undertaker		77. Address of undertaker		78. Telephone number	
79. Name of physician		80. Address of physician		81. Telephone number	
82. Name of registrar		83. Address of registrar		84. Telephone number	
85. Name of informant		86. Address of informant		87. Telephone number	
88. Name of funeral home		89. Address of funeral home		90. Telephone number	
91. Name of cemetery		92. Address of cemetery		93. Telephone number	
94. Name of undertaker		95. Address of undertaker		96. Telephone number	
97. Name of physician		98. Address of physician		99. Telephone number	
100. Name of registrar		101. Address of registrar		102. Telephone number	

BUREAU V. S.

DEC 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13733 CERTIFICATE OF DEATH

1375B32

Reg. Dist. No. 261

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station			
c. LENGTH OF STAY IN 1b 2 1/2 mo.				d. STREET ADDRESS ---			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle --- Last Horsey				4. DATE OF DEATH Month December Day 6th, Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG-28-1877		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Marion Station, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Lord				14. MOTHER'S MAIDEN NAME Eliza Gale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-16-8180		17. INFORMANT Address Deer's Head State Hospital, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 23 19 57 , to December 6 19 57 , that I last saw the deceased alive on December 6, 19 57 , and that death occurred at 7:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/7/57 ACTUAL SIGNATURE L. V. Maldve, M. D. M.D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec. 11, '57		Family Cemetery		Marion Sta, Som. Co, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward				ADDRESS Marion Sta, Md.		24a. REC'D BY REGISTRAR DATE 12-11-57	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68		4. DATE OF BIRTH JUL 15 1899		5. PLACE OF BIRTH Bellingham, Wash.		6. OCCUPATION Retired	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE JUL 15 1925		9. NAME OF SPOUSE Mary Harris		10. DATE OF DEATH DEC 13 1957		11. PLACE OF DEATH Bellingham, Wash.		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension, Atherosclerosis		14. PRESENT ILLNESS Myocardial Infarction		15. DATE OF ONSET DEC 10 1957		16. DATE OF DEATH DEC 13 1957		17. TIME OF DEATH 10:30 AM		18. SIGNATURE OF PHYSICIAN J. H. Harris	
19. SIGNATURE OF NEXT OF KIN Mary Harris		20. ADDRESS 123 Main St, Bellingham, WA		21. CITY Bellingham		22. STATE Washington		23. ZIP CODE 98201		24. TELEPHONE 555-1234	
25. SIGNATURE OF REGISTRAR J. H. Harris		26. ADDRESS 123 Main St, Bellingham, WA		27. CITY Bellingham		28. STATE Washington		29. ZIP CODE 98201		30. TELEPHONE 555-1234	

BUREAU W. I.

DEC 13 1957

RECEIVED

13734

CERTIFICATE OF DEATH

Reg. Dist. No.

33✓

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> 23X1.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>B.7.D#2</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Hudson</u> Last <u>Hudson</u>				4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-1867</u>	9. AGE (In years last birthday) <u>90</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John A. Hudson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Puth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT Address <u>Mr. Rudolph Hudson, Berlin, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Congestive Heart Disease & failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> <u>Unk!</u> (c) <u>Hypertension</u> <u>Unk</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unk</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec. 15, 1957</u> to <u>Dec. 16, 1957</u> , that I last saw the deceased alive on <u>12-15-57</u> , and that death occurred at <u>12:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Sembley</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>12/19/57</u>			
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-19-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u> ADDRESS <u>FUNERAL HOME, Salisbury, Md</u>				24. REC'D BY REGISTRAR <u>DEC 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CHURCH		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF STATE DEPARTMENT OF HEALTH		20. SIGNATURE OF COUNTY BOARD OF HEALTH		21. SIGNATURE OF CITY BOARD OF HEALTH	
22. SIGNATURE OF TOWN BOARD OF HEALTH		23. SIGNATURE OF VILLAGE BOARD OF HEALTH		24. SIGNATURE OF DISTRICT BOARD OF HEALTH	
25. SIGNATURE OF PARISH BOARD OF HEALTH		26. SIGNATURE OF CONGREGATION		27. SIGNATURE OF CHURCH	
28. SIGNATURE OF CEMETERY		29. SIGNATURE OF BURIAL OFFICIAL		30. SIGNATURE OF FUNERAL HOME	
31. SIGNATURE OF STATE DEPARTMENT OF HEALTH		32. SIGNATURE OF COUNTY BOARD OF HEALTH		33. SIGNATURE OF CITY BOARD OF HEALTH	
34. SIGNATURE OF TOWN BOARD OF HEALTH		35. SIGNATURE OF VILLAGE BOARD OF HEALTH		36. SIGNATURE OF DISTRICT BOARD OF HEALTH	
37. SIGNATURE OF PARISH BOARD OF HEALTH		38. SIGNATURE OF CONGREGATION		39. SIGNATURE OF CHURCH	
40. SIGNATURE OF CEMETERY		41. SIGNATURE OF BURIAL OFFICIAL		42. SIGNATURE OF FUNERAL HOME	
43. SIGNATURE OF STATE DEPARTMENT OF HEALTH		44. SIGNATURE OF COUNTY BOARD OF HEALTH		45. SIGNATURE OF CITY BOARD OF HEALTH	
46. SIGNATURE OF TOWN BOARD OF HEALTH		47. SIGNATURE OF VILLAGE BOARD OF HEALTH		48. SIGNATURE OF DISTRICT BOARD OF HEALTH	
49. SIGNATURE OF PARISH BOARD OF HEALTH		50. SIGNATURE OF CONGREGATION		51. SIGNATURE OF CHURCH	
52. SIGNATURE OF CEMETERY		53. SIGNATURE OF BURIAL OFFICIAL		54. SIGNATURE OF FUNERAL HOME	
55. SIGNATURE OF STATE DEPARTMENT OF HEALTH		56. SIGNATURE OF COUNTY BOARD OF HEALTH		57. SIGNATURE OF CITY BOARD OF HEALTH	
58. SIGNATURE OF TOWN BOARD OF HEALTH		59. SIGNATURE OF VILLAGE BOARD OF HEALTH		60. SIGNATURE OF DISTRICT BOARD OF HEALTH	
61. SIGNATURE OF PARISH BOARD OF HEALTH		62. SIGNATURE OF CONGREGATION		63. SIGNATURE OF CHURCH	
64. SIGNATURE OF CEMETERY		65. SIGNATURE OF BURIAL OFFICIAL		66. SIGNATURE OF FUNERAL HOME	
67. SIGNATURE OF STATE DEPARTMENT OF HEALTH		68. SIGNATURE OF COUNTY BOARD OF HEALTH		69. SIGNATURE OF CITY BOARD OF HEALTH	
70. SIGNATURE OF TOWN BOARD OF HEALTH		71. SIGNATURE OF VILLAGE BOARD OF HEALTH		72. SIGNATURE OF DISTRICT BOARD OF HEALTH	
73. SIGNATURE OF PARISH BOARD OF HEALTH		74. SIGNATURE OF CONGREGATION		75. SIGNATURE OF CHURCH	
76. SIGNATURE OF CEMETERY		77. SIGNATURE OF BURIAL OFFICIAL		78. SIGNATURE OF FUNERAL HOME	
79. SIGNATURE OF STATE DEPARTMENT OF HEALTH		80. SIGNATURE OF COUNTY BOARD OF HEALTH		81. SIGNATURE OF CITY BOARD OF HEALTH	
82. SIGNATURE OF TOWN BOARD OF HEALTH		83. SIGNATURE OF VILLAGE BOARD OF HEALTH		84. SIGNATURE OF DISTRICT BOARD OF HEALTH	
85. SIGNATURE OF PARISH BOARD OF HEALTH		86. SIGNATURE OF CONGREGATION		87. SIGNATURE OF CHURCH	
88. SIGNATURE OF CEMETERY		89. SIGNATURE OF BURIAL OFFICIAL		90. SIGNATURE OF FUNERAL HOME	
91. SIGNATURE OF STATE DEPARTMENT OF HEALTH		92. SIGNATURE OF COUNTY BOARD OF HEALTH		93. SIGNATURE OF CITY BOARD OF HEALTH	
94. SIGNATURE OF TOWN BOARD OF HEALTH		95. SIGNATURE OF VILLAGE BOARD OF HEALTH		96. SIGNATURE OF DISTRICT BOARD OF HEALTH	
97. SIGNATURE OF PARISH BOARD OF HEALTH		98. SIGNATURE OF CONGREGATION		99. SIGNATURE OF CHURCH	
100. SIGNATURE OF CEMETERY		101. SIGNATURE OF BURIAL OFFICIAL		102. SIGNATURE OF FUNERAL HOME	

RECEIVED
DEC 27 1957
BUREAU V. 8

13735 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARSONSBURG. xo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSP.</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Goldie</u> <u>ISAAC</u>				4. DATE OF DEATH Month Day Year <u>December 13, 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 18, 1884</u>	
9. AGE (In years last birthday) yrs. <u>73</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Owen Isaac</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Jane Marvel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address <u>Mrs. Clara Dodds, 5041 N. Fairhill St. Philadelphia, Pa.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis - acute</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 hr 10 min</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-6-</u> , 19 <u>57</u> , to <u>12-13-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 13</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Anthony Bernardo</u> M.D.				ADDRESS (Street, city or town, state) <u>Peninsula Gen. Hosp. Salisbury, Md.</u>			
DATE SIGNED <u>12/13/57</u>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		22d. LOCATION (City, town, or county) (State) <u>Milford, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Berry, Jr.</u> ADDRESS <u>Milford, Del.</u>				24. RECEIVED BY REGISTRAR DATE <u>DEC 16 1957</u> REGISTRAR'S SIGNATURE <u>Mary Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13770

CERTIFICATE OF DEATH

13754

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village				e. STREET ADDRESS In village			
3. NAME OF DECEASED (Type or print) First GEORGE Middle TILTON Last JACKSON				4. DATE OF DEATH Month December Day 30th Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 2 Days 13	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Tilghmans Island, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Jackson				14. MOTHER'S MAIDEN NAME Ellen Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Elsie J. Jackson (Wife) Address Pittsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial heart failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) degenerative heart disease. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. 19 p. m. 	Month Day Year 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 10/15 19 57 , to 12/30 19 57 , that I last saw the deceased alive on 12/29 19 57 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 							
ACTUAL SIGNATURE Earl Beardsley M.D.		PHYSICIAN'S NAME (Type) Dr. Earl Beardsley Maryland Ave. Salisbury, Maryland Dec. 30/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-		22b. DATE THEREOF Jan. 2, 1957	22c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery		22d. LOCATION (City, town, or county) (State) Pittsville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR Jan 3 1958		24b. REGISTRAR'S SIGNATURE Mary Holloway	

CERTIFICATE OF DEATH

18750

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Name of Deceased		Place of Birth	
George Jackson		Maryland	
Date of Birth		Place of Death	
October 17, 1875		In Village	
Sex		Color	
Male		White	
Cause of Death		Manner of Death	
Typhoid Fever		Natural	
Date of Death		Place of Burial	
November 10, 1875		In Village	
Age at Death		Sex of Deceased	
34 Years		Male	
Signature of Physician		Signature of Registrar	
J. H. Jackson		J. H. Jackson	

BUREAU V. S.

JAN 3 1908

RECEIVED

13755

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin		c. LENGTH OF STAY IN 1b lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Tyaskin			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAMIE		First INSLEY		Middle JARRETT		Last Dec. 22 1957	
4. DATE OF DEATH Month Dec.		Day 22		Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/20/95	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 5 Days 2 Hours Min. 		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Slemons S. Jarrett				14. MOTHER'S MAIDEN NAME Virginia Messick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Archie Jarrett, Tyaskin, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Aneurysm DUE TO (c) Cerebral INTERVAL BETWEEN ONSET AND DEATH 1 hour ? Cerebral							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 1 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/28 , 19 56 to 12/22 , 19 57 that I last saw the deceased alive on 12/22 , 19 57 , and that death occurred at 12 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Nanticoke Md. DATE SIGNED 12/24/57 ACTUAL SIGNATURE Richard H. Saunders M.D. PHYSICIAN'S NAME (Type) Richard H. Saunders Nanticoke, Maryland 12/26/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/57		22c. NAME OF CEMETERY OR CREMATORY Tyaskin Cem.		22d. LOCATION (City, town, or county) (State) Tyaskin, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. J. Messick				ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR DATE JAN 8 1958	
				24b. REGISTRAR'S SIGNATURE W. J. Messick			

3321 CERTIFICATE OF DEATH

FILE NO.

MARYLAND

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

DEFINITE

UNKNOWN

DIAGNOSIS

SYMPTOMS

TESTS

TREATMENT

PROGNOSIS

REMARKS

SIGNATURE

DATE

PLACE

NAME

ADDRESS

CITY

STATE

COUNTRY

ZIP

TELEPHONE

FAX

E-MAIL

WWW

ICQ

MSN

SKYPE

YAHOO

AIM

BUREAU V. S.

JAN 8 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G224 1-3-58 et

13736

CERTIFICATE OF DEATH

13756 332
Reg. Dist. No. 264-

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARION STATION</u> 19x0.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>RT. #1 - Box 366</u>	
3. NAME OF DECEASED (Type or print) <u>Nathaniel</u> First Middle Last		4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 6 - 1906</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR: Months <u>51</u> Days <u>19</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARION SOMERSET U.S.A.</u>
13. FATHER'S NAME <u>Levin Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah MARSHALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-8071</u>	17. INFORMANT <u>HELELYN JOHNSON, MARION M</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Posterior Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Arteriosclerotic Cardiovascular Dis.</u> (c) <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12/17</u> , 19 <u>57</u> , to <u>12/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/18</u> , 19 <u>57</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>321 S. D. St. Salisbury, Md.</u>	
DATE SIGNED <u>12/20/57</u>			
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/22/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>
22d. LOCATION (City, town, or county) <u>Marion Sta., Som Co. Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Marion Sta., Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>12-22-57</u>		24b. REGISTRAR'S SIGNATURE <u>William D. Payne</u> <u>Mary H. Holloway</u>	

CERTIFICATE OF DEATH

Name of Deceased William J. ...		Sex Male	
Age 20 years		Date of Birth ...	
Cause of Death ...		Date of Death ...	
Place of Death ...		Signature of Physician ...	
Signature of Registrar ...		Signature of Coroner ...	

BUREAU V. E.

DEC 10 1957

RECEIVED

13772

CERTIFICATE OF DEATH

Reg. Dist. No. 33 ✓

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Head Of Creek</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida B. Jones</u>		4. DATE OF DEATH Month Day Year <u>12 10 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO. <u>Mathew Jones</u>	
17. INFORMANT <u>Quantico Md. R. F. 1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>10 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/1</u> , 19 <u>54</u> , to <u>12/10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/10</u> , 19 <u>57</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Richard H. Saunders, M.D. Nantuxee Md. 12/12/57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>RICHARD H. SAUNDERS.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Head of Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Wicomico Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		24a. REC'D BY REGISTRAR <u>DEC 18 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 18 1957

BUREAU V. S.

CERTIFICATE OF DEATH

STATE OF NEW YORK - BUREAU OF HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13737

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13758 33x

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dagsboro, Delaware 46X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ruby Opal Long			4. DATE OF DEATH Month 12 Day 26 Year 57		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 5, 1914		9. AGE (In years last birthday) 43 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teaching (School)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oklahoma	
13. FATHER'S NAME J. A. Crull			14. MOTHER'S MAIDEN NAME Ellen Northrop Crull		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Harry o. Long Dagsboro, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull: intracranial hemorrhage. 2 days 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injured in an automobile accident. Old Dalmar Rd.			
20c. TIME OF INJURY Month 11 Day 20 Year 57 a. A.M. 12-23-57 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Salisbury		20g. (County) Wicomico		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12-27-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-57		22c. NAME OF CEMETERY OR CREMATORY Red Mens Cemetery	
22d. LOCATION (City, town, or county) Dagsboro, Del.		(State) Del.			
23. FUNERAL DIRECTOR'S SIGNATURE Watson & Gray Millsboro, Del.		ADDRESS		24a. REC'D BY REGISTRAR DEC 31 1957	
				24b. REGISTRAR'S SIGNATURE Mary Holloway	

STATE OF NEW YORK
DEPARTMENT OF HEALTH

STATE DEPARTMENT OF HEALTH—BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 31 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 33 ✓

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 THASKIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82. PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EVELYN</u>		First Middle Last <u>MASON</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER 2 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-3-78</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Jones</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Blacks Butts, Thaskin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis 10 years</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/27</u> , 19 <u>57</u> to <u>12/2</u> , 19 <u>57</u> . That I last saw the deceased alive on <u>12/2</u> , 19 <u>57</u> , and that death occurred at <u>9:05</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>NANTICOK MD</u> DATE SIGNED <u>12/4/57</u>							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.		PHYSICIAN'S NAME (Type) <u>RICHARD H. SAUNDERS, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thaskin, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Thaskin, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Messick, Pinalva, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
HUSBAND		WIFE		CHILD		SISTER		BROTHER		PARENT		GRANDPARENT		OTHER	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		MARRIAGE		MARRIAGE		MARRIAGE		MARRIAGE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CITY		STATE	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	

RECEIVED
DEC 10 1957
BUREAU V. S.

13739

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worc.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> 23X2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>RENISULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>110 W. Wicomico ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>Wilmer</u> Middle <u>O.</u> Last <u>Messick</u>				4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-4-87</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired police</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-12-1062</u>		17. INFORMANT <u>Family</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cor Pulmonale with Congestive Failure</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Infiltration - Cause</u> DUE TO (c) <u>undetermined</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>57</u> , to <u>Dec 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>57</u> , and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D. _____ PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u>				ADDRESS <u>1308. Fort Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 10 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ILLINOIS STATE DEPARTMENT OF HEALTH—BUREAU OF VITAL RECORDS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13761

13740

CERTIFICATE OF DEATH

Reg. Dist. No.

33✓

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 14 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deal Island	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS --		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dossie Middle Vealie Last Milbourne				4. DATE OF DEATH Month Dec. Day 8, Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 29, 1878	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Deal Island, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Levin Milbourne				14. MOTHER'S MAIDEN NAME Margaret Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Deer's Head State Hospital, Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Ca. of right face 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) 191X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from October 3, 1957 to Dec. 8, 1957 that I last saw the deceased alive on Dec. 8, 1957 and that death occurred at 9:55 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/9/57 ACTUAL SIGNATURE L. V. Maldve M.D. Deer's Head State Hospital 12/9/57 PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/57		22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or county) Deal Island Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. V. Maldve ADDRESS Deal Island				DATE 12/12/57		24b. REGISTRAR'S SIGNATURE Lala J. Whittier	

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 2 1958

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13762
13741 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 9 FilmG223 12-19-57 et

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 205 Walnut St			d. STREET ADDRESS 205 Walnut Street		
3. NAME OF DECEASED (Type or print) First AGNES Middle N Last MITTEN			4. DATE OF DEATH Month DECEMBER Day 1 st Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, Approx. 60 yrs.		9. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
12. CITIZEN OF WHAT COUNTRY U S A			13. FATHER'S NAME Elmer E. Estes		
14. MOTHER'S MAIDEN NAME Thressa Sutton			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Wendell Vickers (Friend) Address 825 Roslyn Ave. Cambridge, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardio-vascular disease- (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					INTERVAL BETWEEN ONSET AND DEATH Sudden. Years.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury		20g. (County) Wicomico		20h. (State) Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Dr. Earl L. Royer			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED December 2 1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 4, 1957		22c. NAME OF CEMETERY OR CREMATORY Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte FUNERAL SERVICE - CAMBRIDGE, MARYLAND			24a. REC'D BY REGISTRAR 12/4/57		
24b. REGISTRAR'S SIGNATURE Mary H. Holloway					

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 10 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 10, 11, 13, 14 Film 6223 12-30-57 et
13742
CERTIFICATE OF DEATH

13763

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Salisbury</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>4 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u> <u>1939.2</u>	
		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>L.</u> Last <u>NELSON</u>		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22 1870</u>
9. AGE (In years last birthday) yrs. <u>87</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Merchandise</u>	
11. BIRTHPLACE (State or foreign country) <u>Crisfield, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Lorenzo Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Lawson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Cardiovascular Renal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 22</u> , 19 <u>57</u> , to <u>12-19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-19</u> , 19 <u>57</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip A. Tusk</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>12-20-57</u>	
PHYSICIAN'S NAME (Type) <u>Philip A. Tusk</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 22, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CRISFIELD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CRISFIELD, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BROADBENT SONS - CRISFIELD, MD.</u> <u>Robert H. Broadbent</u>		24. REC'D BY REGISTRAR DATE <u>DEC 23 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mary Hallway</u> <u>ET</u>	

DEC 1963

RECEIVED

THE UNIVERSITY OF CHICAGO

10. 11. 1954

13743

CERTIFICATE OF DEATH

13764 337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>404 1/2 CAMDEN AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Washington NELSON</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER 2 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 13-1891</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>8 19</u>		IF UNDER 24 HRS. Hours Min. <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Thomas Henry Purcell</u>				14. MOTHER'S MAIDEN NAME <u>Ella Rhee Bradley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Herman E. Coulter (Daughter)</u> Address <u>118 Van Buren St. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fradlandes Pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>16 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE <u>260X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/25</u> , 19 <u>57</u> , to <u>12/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>57</u> , and that death occurred at <u>2:14</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew C. Mitchell</u> M.D.				ADDRESS (Street, city or town, state) <u>211 Maryland Ave Salisbury, Md.</u>			
DATE SIGNED <u>12/2/57</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Andrew C. Mitchell</u>				DATE <u>12-2-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME</u>				ADDRESS <u>SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 5 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Pittsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XX XX		d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GATTIE HULDA PALMER		4. DATE OF DEATH Month Day Year Dec. 14, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Smith	
14. MOTHER'S MAIDEN NAME Rachel Baker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 212-10-9084	
16. SOCIAL SECURITY NO. 212-10-9084		17. INFORMANT Address F. T. Palmer Pittsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Hypertension-arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 weeks ago - pulmonary infarct (x-ray diagnosis - PG Hospital) (c) 6 weeks ago - pulmonary infarct (x-ray diagnosis - PG Hospital) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 6 weeks ago - pulmonary infarct (x-ray diagnosis - PG Hospital)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 1, 1957 , to 12-14-1957 , that I last saw the deceased alive on 12-14-1957 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank R. Lewis		ADDRESS (Street, city or town, state) DATE SIGNED Wicomico Maryland	
PHYSICIAN'S NAME (Type) Peter Whaley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/17/57	22c. NAME OF CEMETERY OR CREMATORY Pittsville	22d. LOCATION (City, town, or county) (State) Pittsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley		24a. REC'D BY REGISTRAR DEC 23 1957	24b. REGISTRAR'S SIGNATURE Mary Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G223 12-30-57 et
13744 CERTIFICATE OF DEATH

137653 ✓
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prick</u> 19x2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>E</u> Last <u>Parks</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 23, 1884</u>	9. AGE (In years last birthday) <u>48 2/3</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William John Tyler</u>				14. MOTHER'S MAIDEN NAME <u>Estella Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>219-16-479</u>		17. INFORMANT <u>Mr. Walter Parks</u>		Address <u>Orville Mc</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Breast & Metastasis to Brain. fracture left hip</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 15, 1957</u> to <u>Dec. 8, 1957</u> , that I last saw the deceased alive on <u>Dec. 8, 1957</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Fortune</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u>			
PHYSICIAN'S NAME (Type) <u>David Fortune</u>				DATE SIGNED <u>Dec 8, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Orville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Orville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin Wilson Princes</u>				ADDRESS <u>Orville Md</u>		24a. REC'D BY REGISTRAR <u>17 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

DEC 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 Union Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 104 Union Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Esther Last Parsons		4. DATE OF DEATH Month Dec. Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1903.
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months 9 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Delmar Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Greensbury Parsons		14. MOTHER'S MAIDEN NAME Laxenia Elizabeth Hastings.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 104 Union Ave. Salisbury, Maryland.	
17. INFORMANT Mr. Purnell W. Parsons (Husband)		Address 104 Union Ave. Salisbury, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breasts with metastasis DUE TO throughout both lungs and left femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 to Dec 10 , 19 57 , that I last saw the deceased alive on Dec 8 , 19 57 , and that death occurred at 1:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 303 East Street Delmar DATE SIGNED 12-10-57			
ACTUAL SIGNATURE L.V. Sohler M.D.			
PHYSICIAN'S NAME (Type) Dr. L.V. Sohler 303 East Street, Delmar, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 12, 1957.	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery.	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company. ADDRESS Salisbury, Maryland.		24a. REC'D BY REGISTRAR C 11 1957 24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13746

CERTIFICATE OF DEATH

13768 337
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Pen. Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 133 Truitt e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADDIE Last PHILLIPS		4. DATE OF DEATH Month DECEMBER Day 22 Year nd 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1920
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Sydney E. Lewis		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. E. Carlyle Phillips (Husband)		133 Truitt St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary + Cardiac infarction 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of left breast DUE TO (c) 15 mo.		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8:15 , 19 56 , to 12:22 , 19 57 , that I last saw the deceased alive on 12:22 , 19 57 , and that death occurred at 4:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE H. Briele		M.D.	
PHYSICIAN'S NAME (Type) Dr. Henry Briele		Medical Center - Salisbury, Maryland Dec. 23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 24, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME * SALISBURY, MD.		24a. REC'D BY REGISTRAR DEC 27 1957 24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		1957	
Place of Birth		Place of Death	
Baltimore		Baltimore	
Age		Sex	
65		Male	
Race		Cause of Death	
White		Heart Disease	
Marital Status		Occupation	
Married		Retired	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

RECEIVED
BUREAU V. 1
DEC 27 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13747 CERTIFICATE OF DEATH

Reg. Dist. No.

1376933y

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-POCOMOKE CITY</u>	
c. LENGTH OF STAY IN 1b <u>4 WEEKS</u>		d. STREET ADDRESS <u>RFD #2 23X1.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING HILL NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>M.</u> Last <u>PILCHARD</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 3, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES T. ARDIS</u>		14. MOTHER'S MAIDEN NAME <u>HARRIETT BONNEVILLE</u>	
15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>231-46-3172</u>	
17. INFORMANT <u>MRS GEORGE WATERFIELD, POCOMOKE, MD.</u>		Address <u>POCOMOKE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-9</u> , 19 <u>57</u> , to <u>12-9</u> , 19 <u>57</u> that I last saw the deceased alive on <u>12-9</u> , 19 <u>57</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William E. Ellis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>12-9-57</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BAPTIST CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Watson</u>		ADDRESS <u>POCOMOKE, MD.</u>	24. REC'D BY REGISTRAR <u>DEC 16 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

DEC 16 1957

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

DATE DEC 10 1955

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		ARMY SERVICE		MARINE SERVICE		COAST GUARD SERVICE		OTHER SERVICE		REMARKS					
CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		INTERMEDIATE CAUSE		UNDERLYING CAUSE		PREEXISTING DISEASE		ACUTE DISEASE		CHRONIC DISEASE		INFECTIOUS DISEASE		TOXIC DISEASE		TRAUMATIC DISEASE		OTHER DISEASE					
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF VENDOR		SIGNATURE OF WITNESS		SIGNATURE OF OTHER		SIGNATURE OF OTHER		SIGNATURE OF OTHER		SIGNATURE OF OTHER					

BUREAU V. S.

DEC 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13749

CERTIFICATE OF DEATH

Reg. Dist. No.

1377537

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS Main St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLARD Middle LEONARD Last PUSEY				4. DATE OF DEATH Month DECEMBER Day 29th Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1906		9. AGE (In years last birthday) yrs. 51	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Princess Anne, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jefferson D. Pusey				14. MOTHER'S MAIDEN NAME Pearl Heath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Helen J. Pusey (Wife) Fruitland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pericarditis, Adhesions DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x Rheumatoid Arthritis							INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month Dec	Day 28	Year 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 12/28 , 19 57 to 12/29 , 19 57 that I last saw the deceased alive on 12/28 , 19 57 , and that death occurred at 12:25 AM , from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE Rufus S. Hardner Jr.				ADDRESS (Street, city or town, state) 3215 Div. St. DATE SIGNED Dec. 130 57			
PHYSICIAN'S NAME (Type) Dr. Rufus S. Hardner Jr.		S. Division St. Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 31, 1957	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24. REC'D BY REGISTRAR JAN 3 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Physician		Manner of Death	
John Doe		Male		45		Jan 1, 1900		New York City		New York City		Heart Disease		Jan 15, 1945		New York City		Dr. J. Smith		Natural	
John Doe		Male		45		Jan 1, 1900		New York City		New York City		Heart Disease		Jan 15, 1945		New York City		Dr. J. Smith		Natural	

[Faint, illegible text, likely a signature or official statement]

BUREAU V. S.

IAN 3 1958

RECEIVED

Date of Death		Place of Death		Physician		Manner of Death	
Jan 15, 1945		New York City		Dr. J. Smith		Natural	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13750

CERTIFICATE OF DEATH

Reg. Dist. No.

13772337

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 5½ years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. STREET ADDRESS 31 N. Carey Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle Putsche Last Putsche				4. DATE OF DEATH Month December Day 11 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/19/1872	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 8 Days 5 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Frederick Putsche				14. MOTHER'S MAIDEN NAME Nellie Manning			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) —							
INTERVAL BETWEEN ONSET AND DEATH 10 days Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury				20g. (County) Salisbury		20h. (State) Maryland	
21. I certify that I attended the deceased from April 1, 19 52 to December 11, 19 57 that I last saw the deceased alive on Dec. 11, 19 57 and that death occurred at 4:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/12/57							
ACTUAL SIGNATURE L. V. Maldve, M. D.				M.D. Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD.				24. REC'D BY REGISTRAR DEC 16 1957			
24b. REGISTRAR'S SIGNATURE Mary Holloway							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 1

DEC 16 1957

RECEIVED

13751

CERTIFICATE OF DEATH

13773

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 13 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 07X02			
3. NAME OF DECEASED (Type or print) First Marshall Middle Ae Last Ragan				4. DATE OF DEATH Month Dec. Day 29 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/1/1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.		IF UNDER 24 HRS. Months 62 Days 62 Hours 62 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Stephen Ragan				14. MOTHER'S MAIDEN NAME Mabel Alexander			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Degenerative heart disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 13, 1956 , to Dec. 29, 1957 , that I last saw the deceased alive on Dec. 29, 1957 , and that death occurred at 11:05 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Dr. V. Juerman M.D.				Deer's Head State Hospital 12/30/57			
PHYSICIAN'S NAME (Type) Dr. V. Juerman				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 2 1958		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Pa, near Peach Bottom Pa.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Carl Tyson, Rising Sun, Md.				24a. REC'D BY REGISTRAR JAN 2 1958		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. R.

JAN 2 1958

RECEIVED

CERTIFICATE OF DEATH

13774337
Reg. Dist. No.

13752

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>23x2.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>WEST ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>B.</u> Last <u>RAVNE</u>				4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 27, 1885</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD RFD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>							
13. FATHER'S NAME <u>SEWELL DEYNNIS</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN HOLLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>MRS EUNICE FISITER</u> Address <u>BERLIN MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1) HEPATIC FAILURE</u> DUE TO <u>159X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2) ADENOCARCINOMA, HEPATIC</u> DUE TO (c) <u>3) CARCINOMA, G-I TRACT(?)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS.</u> ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/28</u> , 19 <u>57</u> , to <u>12/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/12</u> , 19 <u>57</u> , and that death occurred at <u>11:22P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr</u> M.D.				ADDRESS (Street, city or town, state) <u>321 S. DIV ST, SALISBURY, MD</u>			
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR</u>				DATE SIGNED <u>12/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burbage</u> ADDRESS <u>Berlin MD</u>				24a. REC'D BY REGISTRAR <u>DEC 16 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH-19

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 16 1957

RECEIVED

1

13753

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13775337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GEN Hosp</u>		d. STREET ADDRESS <u>504 COLLINS ST.</u>	
3. NAME OF DECEASED (Type or print) <u>Elmer</u> First <u>D. Shockley</u> Middle <u>Shockley</u> Last		4. DATE OF DEATH <u>12</u> Month <u>12</u> Day <u>1957</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>A.A.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHICKEN PLANT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>KATE Shockley</u>		14. MOTHER'S MAIDEN NAME <u>NORA Shockley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-10-9802</u>	
17. INFORMANT <u>Elton Shockley</u> Address <u>504 COLLINS ST. SALISBURY, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Renal</u> DUE TO (c) <u>Insulin Shock</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>210X Insulin Shock - Diabetes</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 8, 1957</u> to <u>Dec. 12, 1957</u> that I last saw the deceased alive on <u>Dec. 12, 1957</u> , and that death occurred at <u>740</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Sempley</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>12/16/57</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Sempley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HUTTS CHAPEL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>NEAR SNOW HILL, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Stewart</u> ADDRESS <u>FUNERAL HOME, SALISBURY, MD</u>		24a. REC'D BY REGISTRAR <u>DEC 19 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

BUREAU V. S.

DEC 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13754 CERTIFICATE OF DEATH

Reg. Dist. No.

13776 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 152 Upton St		d. STREET ADDRESS 152 Upton St	
3. NAME OF DECEASED (Type or print) ANNA BEULAH BENTON SMITH		4. DATE OF DEATH December 7 th 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1866
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Railroad Clerk	
11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Robert Pollitt		14. MOTHER'S MAIDEN NAME Susan Amelia Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet, no. or unknown) No (If yes, give war or dates of service)		17. INFORMANT Mrs. Gordon Bennett (Daughter) Address 152 Upton St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Antisepsis DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 19 54 to 12/7 19 57 , that I last saw the deceased alive on 12/7/57 , 19_____, and that death occurred at 11:50 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED Dec 7 / 57 ACTUAL SIGNATURE F. R. Gramse M.D. Salisbury, Md. PHYSICIAN'S NAME (Type) Dr. Fred Gramse S. Division St. Salisbury, Maryland Dec 7 / 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 10, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. ADDRESS		24a. REC'D BY REGISTRAR DEC 11 1957	24b. REGISTRAR'S SIGNATURE Mary Holloway

DEC 11 1957

RECEIVED

13755 CERTIFICATE OF DEATH

Reg. Dist. No.

1377332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>702 Baker St</u>	
3. NAME OF DECEASED (Type or print) First <u>Eda</u> Middle <u>Gertrude</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 3-</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home - None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laurel Delaware</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Prettyman</u>		14. MOTHER'S MAIDEN NAME <u>MARANDA Ellis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mrs. Van Smith (Husband)</u>	
17. INFORMANT <u>702 Baker St. Salisbury Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status Asthmaticus</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchial Asthma</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity - Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:40</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Alberta Mattax</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Alberta Mattax - Camden Ave - Salisbury Md. 12/9/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>Dec 12 1957</u>	<u>Laurel Hill Cemetery</u>	<u>Laurel Delaware</u>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
<u>Holloway & Co. Funeral Home - Salisbury Md</u>		<u>DEC 11</u>	<u>Mary M. Holloway</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 11 1957

RECEIVED

13756 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 1 Film G224 1-2-58 et
 CERTIFICATE OF DEATH

13778331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 18 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private residence				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle H. Last Speights				4. DATE OF DEATH Month Dec. Day 22 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-I-1863	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jerimiah T. Speights				14. MOTHER'S MAIDEN NAME Susan Tull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Lawson F. Reichard Address Westover, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Cardiac Paralysis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardio vascular renal disease							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-21 , 19 56 , to 12-22 , 19 57 , that I last saw the deceased alive on 12-21 , 19 57 , and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Insley M.D.				ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 12-24-57			
PHYSICIAN'S NAME (Type) Philip A. Insley							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-24-1957		22c. NAME OF CEMETERY OR CREMATORY St. Andrew Cemetery		22d. LOCATION (City, town, or county) (State) Princess Anne, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Heim R. Wilson				ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR Mary Holloway	

DEC 30 1957

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Charles		Male		30		1957	
Place of Birth		Race		Occupation		Cause of Death	
Maryland		White		Teacher		Heart Disease	
Residence		Marital Status		Education		Date of Burial	
Baltimore		Married		High School		1957	
Funeral Home		Physician		Manner of Death		Place of Burial	
Johns Hopkins		Dr. Smith		Natural		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Issuance		Place of Issuance		Signature of Issuer		Signature of Witness	
1957		Baltimore		[Signature]		[Signature]	

RECEIVED
DEC 30 1957
BUREAU V. S.

1377733 ✓

13757

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne's ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN lb 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 17X02			
3. NAME OF DECEASED (Type or print) First Walter Middle Summers Last Summers				4. DATE OF DEATH Month December Day 23 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/12/1893	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker				10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Albert Summers				14. MOTHER'S MAIDEN NAME Lucy Watkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca. of prostate gland with generalized metastases DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastases DUE TO (c) 2 yrs						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 28 1957 , to Dec. 23 1957 , that I last saw the deceased alive on Dec. 23 1957 , and that death occurred at 8:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. V. Juerman				ADDRESS (Street, city or town, state) Deer's Head State Hospital			
DATE SIGNED 12/24/57							
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-31-57		22c. NAME OF CEMETERY OR CREMATORY Penitentiary		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Dorothy M. West				ADDRESS 17X02		24a. REC'D BY REGISTRAR DATE 1/2/58	
24b. REGISTRAR'S SIGNATURE Mary J. Holloway							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

3 3 3

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13780

13758

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Salisbury Wicomico County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 1 yr. 10 mos.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Maryland 14X0.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 227 S. Queen Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Melissa Middle Thomas Last Thomas		4. DATE OF DEATH Month December Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk		10b. KIND OF BUSINESS OR INDUSTRY Chestertown, Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Hill		14. MOTHER'S MAIDEN NAME Nancy Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic stenosis and insufficiency 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) General arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Unk Unk Unk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 9 , 19 56 , to Dec. 13 , 19 57 , that I last saw the deceased alive on Dec 13 , 19 57 , and that death occurred at 8:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 12/14/57			
ACTUAL SIGNATURE Gerhard Kosmahly M.D.		PHYSICIAN'S NAME (Type) Gerhard Kosmahly, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/17/57	22c. NAME OF CEMETERY OR CREMATORY James Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Herbert Waller		24a. REC'D BY REGISTRAR DATE 12/15/57	
ADDRESS Chestertown, Maryland		24b. REGISTRAR'S SIGNATURE Mary K. Holloway	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

DEC 19 1957

RECEIVED

13774

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown - Rural				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home				d. STREET ADDRESS Brookview			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ida Middle May Last Wainwright				4. DATE OF DEATH Month December Day 10 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 31, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Corkran				14. MOTHER'S MAIDEN NAME Elizabeth Rhodes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT G. Garland Wainwright, Rhodesdale, Md., RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malonistic barcoma of neck 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Sharptown, Maryland				20g. (County) Sharptown, Maryland		20h. (State) Sharptown, Maryland	
21. I certify that I attended the deceased from Dec 8, 1957 , to Dec 10, 1957 , that I last saw the deceased alive on Dec 9, 1957 , and that death occurred at 2304 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharptown, Maryland DATE SIGNED 12-12-57							
ACTUAL SIGNATURE H. S. Kuhlman M.D. Sharptown, Maryland							
PHYSICIAN'S NAME (Type) H. S. Kuhlman, M.D. Sharptown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery	
22d. LOCATION (City, town, or county) Brookview, Maryland				22e. (State) Sharptown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalburg, Maryland				24a. REC'D BY REGISTRAR DEC 16 1957		24b. REGISTRAR'S SIGNATURE Maryl C. Owens	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13759

CERTIFICATE OF DEATH

13782

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> 46 X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R7D#2</u>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>CATHERINE</u> Last <u>Walter</u>				4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 1, 1914</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. B.</u>							
13. FATHER'S NAME <u>GEORGE W. MOSLEE</u>				14. MOTHER'S M maiden NAME <u>ESSIE F. HATTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>				17. INFORMANT <u>WM L. WALTER, SAME</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>757.1</u> DUE TO <u>Chemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Poly cystic Disease of Kidney</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subarachnoid Hemorrhage</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 11, 1957</u> to <u>Dec 22, 1957</u> , that I last saw the deceased alive on <u>Dec 22, 1957</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>224 N. Division St. Salisbury, Md.</u>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12/27/57</u>		<u>HEBRON CEM.</u>		<u>HEBRON, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, MD</u> <u>Norman F. Baker</u>				24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13760

CERTIFICATE OF DEATH

13783

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 7mo. 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Dames Quarter 19X1.2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Emma Middle White Last White				4. DATE OF DEATH Month Dec. Day 8 Year 19 57			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 17, 1878	
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk				10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel Holland				14. MOTHER'S MAIDEN NAME Unk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk				16. SOCIAL SECURITY NO. unk		17. INFORMANT Hospital Records Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of rt. lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unk							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 2, 19 57, to Dec. 8, 19 57, that I last saw the deceased alive on Dec. 8, 19 57, and that death occurred at 2:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 12/8/57							
ACTUAL SIGNATURE L. Maldve				M.D. Salisbury, Maryland			
PHYSICIAN'S NAME (Type) L. Maldve, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12/18/57		macordonia		Dames Quarter Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Funeral Home, Inc.				ADDRESS		24a. REC'D BY REGISTRAR DEC 10 1957	
						24b. REGISTRAR'S SIGNATURE Maugh Holloway	

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		1892		BALTIMORE, MARYLAND	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1915		BALTIMORE		JANE HARRIS		1957		BALTIMORE	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
LABORER		1957		BALTIMORE		BALTIMORE		1957		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1957		BALTIMORE		DR. J. H. HARRIS		1957		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1957		BALTIMORE		DR. J. H. HARRIS		1957		BALTIMORE	
PLACE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HOME		1957		BALTIMORE		DR. J. H. HARRIS		1957		BALTIMORE	
DATE OF DEATH		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN	
1957		BALTIMORE		DR. J. H. HARRIS		1957		BALTIMORE		DR. J. H. HARRIS	
NAME OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE		PLACE	
DR. J. H. HARRIS		1957		BALTIMORE		DR. J. H. HARRIS		1957		BALTIMORE	
DATE OF DEATH		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN	
1957		BALTIMORE		DR. J. H. HARRIS		1957		BALTIMORE		DR. J. H. HARRIS	
NAME OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE		PLACE	
DR. J. H. HARRIS		1957		BALTIMORE		DR. J. H. HARRIS		1957		BALTIMORE	

BUREAU V. S.

DEC 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13761

CERTIFICATE OF DEATH

13784

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsbury	
c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Minnie Middle F. Last White		4. DATE OF DEATH Month Dec. Day 15 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua Beathard		14. MOTHER'S MAIDEN NAME Martha Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Ida White (Daughter-in-Law) Parsonsburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized (c) Arteriosclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 3 days Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old fracture of left femur			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 11 , 19 57 , to Dec. 15 , 19 57 , that I last saw the deceased alive on Dec. 15 , 19 57 , and that death occurred at 7:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/16/57 ACTUAL SIGNATURE L. V. Maldve PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 18, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsonsbury Cemetery	22d. LOCATION (City, town, or county) (State) Parsonsbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DEC 19 1957	24b. REGISTRAR'S SIGNATURE Mary Holloway

RECEIVED

DEC 19 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. DATE OF DEATH	
10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR	
12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED	
14. SIGNATURE OF NEXT OF KIN	
15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME	
17. SIGNATURE OF CEMETERY	
18. SIGNATURE OF OTHER	
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100. SIGNATURE OF OTHER	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18785
13775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13785

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethel 46X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cor. of Locust Ter. & W. Locust St.		d. STREET ADDRESS R.D. #	
3. NAME OF DECEASED (Type or print) First NOLAN Middle BRADFORD Last WILLEY		4. DATE OF DEATH Month December Day 1st Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2nd, 1941
9. AGE (In years last birthday) 16 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer on Farm		10b. KIND OF BUSINESS OR INDUSTRY Chicken Grower	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Bradford M. Willey		14. MOTHER'S MAIDEN NAME Marie O. Niblett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Marie Taylor (Mother)		Address Bethel Delaware	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet Wound of Head 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Golden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr/ Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 2 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 5, 1957	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DEC 5 1957	
24b. REGISTRAR'S SIGNATURE Mary Holloway			

FOR DATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 5 1957
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13776

CERTIFICATE OF DEATH

13786

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		STATE <i>md</i> COUNTY <i>Wicomico</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Delmar</i>		TOWN <i>Delmar md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Halloway nursing home</i>		LENGTH OF STAY (in this place) <i>40</i>		STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Nicodemus Wilson</i>				4. DATE OF DEATH (Month) <i>12</i> (Day) <i>25</i> (Year) <i>1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>wid</i>	8. DATE OF BIRTH <i>1867</i>	9. AGE last birthday <i>90</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>?</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Lorraine Halloway</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <i>Arterio-sclerotic Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>unk.</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio sclerosis</i>				7 years?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Hypertension</i>				<i>unk.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<i>1 year</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg. etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <i>?</i>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec 9, 1957</i> , to <i>Dec 25, 1957</i> , that I last saw the deceased alive on <i>Dec 25, 1957</i> , and that death occurred at <i>?</i> M, from the causes and on the date stated above. SIGNATURE <i>H. Herbert Semblay</i> DATE SIGNED <i>12/28/57</i> ADDRESS (Street, city, town, state) <i>Salisbury Md</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>12-28-57</i>		NAME OF CEMETERY OR CREMATORY <i>Union Cem</i>		LOCATION (City, town, or county) (State) <i>Delmar md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Brooks</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Brooks</i>		ADDRESS	
DATE <i>DEC 30 '57</i>							

